MEDDAC Regulation 40-29

Medical Services

Pain Assessment and Management

Headquarters
U.S. Army Medical Department Activity
Fort George G. Meade
2480 Llewellyn Avenue
Fort George G. Meade, MD 20755-5800
26 August 2002

Unclassified

SUMMARY of CHANGE

MEDDAC REG 40-29
Pain Assessment and Management

Specifically, this revision—

- Has been published in a new format that includes a cover and this "Summary of Change" page.

- Reformats the title page. The Contents section now includes the page numbers that the various chapters and paragraphs begin on.

- An additional reference, VHA/DoD Clinical Practice Guideline for Management of Post-operative Pain, was added (appendix A).

Department of the Army
Headquarters
United States Army Medical Department Activity
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Pain Assessment and Management

FOR THE COMMANDER:

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Adjutant

History. This is the first revision of this publication. It was originally published on 14 May 2001.

Summary. This regulation covers the policies and procedures for assessing and managing pain.

Applicability. This regulation applies to all elements of the U.S. Army Medical Department Activity, Fort George G. Meade (MEDDAC).

Proponent. The proponent of this regulation is the Chief, Musculoskeletal Center, Department of Specialty Care.

Supplementation. Supplementation of this regulation is prohibited.

Suggested improvements. Users of this publication are invited to send comments and suggested improvements, by memorandum, directly to the Commander, U.S. Army Medical Department Activity, ATTN: MCXR-DSC-MSC-PT, Fort George G. Meade, MD 20755-5800, or to the MEDDAC's Command Editor by fax to (301) 677-8088 or e-mail to john.schneider@na.amedd.army.mil.

Distribution. Distribution of this publication is by electronic medium only.

Contents (Listed by paragraph and page number)

* This publication supersedes MEDDAC Reg 40-29, dated 14 May 2001

Contents–continued

Chapter 1
Introduction

1-1. Purpose
To establish responsibilities, policies and procedures to assess and manage pain within the MEDDAC's medical treatment facilities.

1-2. References
Related publications and referenced forms are listed in the appendix A.

1-3. Explanation of abbreviations
Abbreviations used in this regulation are explained in the glossary.

1-4. Responsibilities
a. *The Deputy Commander for Clinical Services (DCCS).* The DCCS will—

(1) Ensure this regulation is complied with throughout the MEDDAC.

(2) Ensure all physician and physician assistant providers, throughout the MEDDAC, receive training in pain assessment and effective pain management.

b. *The Deputy Commander for Nursing (DCN).* The DCN will—

(1) Ensure all nursing personnel, throughout the MEDDAC, receiving training in pain assessment and treatment.

(2) Implement a pain assessment and management training program throughout the MEDDAC for nursing and other non-credentialed health care staff members.

c. *Department and clinic chiefs*. Department and clinic chiefs will—

(1) Ensure all applicable members of their staffs receive pain assessment and management training.

(2) Ensure their staffs comply with the provisions of this regulation.

(3) Ensure copies of the MEDDAC's patient's rights and responsibilities regarding pain are posted in all clinics, and that pain control pamphlets are available in all clinics.

(4) Incorporate pain assessment into medical record review criteria.

d. *The Chief, Pharmacy Service.*

The Chief, Pharmacy Service will—

(1) Standardize patient education material available via the Composite Health Care System for pain medications and distribute these to patients upon request.

(2) Provide additional information and professional advice specific to each patient while screening for drug interactions and monitoring for appropriate dosing.

(3) Monitor, evaluate and review pain medications prescribed by the MEDDAC's providers and utilize these reviews to make recommendations through the Drug Use Evaluation and Pharmacy and Therapeutics committees for additions and deletions to the formulary.

(4) Maintain and update a list of pain control medications, proper dosages and comments to assist providers in pain management.

Chapter 2
Philosophy and Goal of Pain Management, and Staff Education

2-1. Philosophy and goal of pain management

a. The relief of pain and suffering is integral to the MEDDAC's mission. Consistent with the national agenda of improved pain management, the Command has made the relief of pain a priority for the organization. The goal of pain management is to relieve the physical and psychosocial symptoms associated with pain while maintaining the patient's level of function and promoting optimal recovery and healing.

b. The MEDDAC's commitment to improve pain management is based on an emerging body of scientific knowledge derived from groups such as the American Pain Society and the Agency for Health Care Policy and Research. Documentation produced by these groups serve as the national standard for improved pain management, have served as the basis for Joint Commission on Accreditation of Health Care Organizations' pain standards, and are accepted as the national standards for improved pain management.

c. All patients have the right to appropriate assessment and management of pain. Pain assessment will be considered the "fifth" vital sign. Pain intensity ratings will be recorded during the screening process, along with the patient's temperature, pulse, respiration and blood pressure. A statement the patient's rights and responsibilities in regards to pain will be posted in all clinics. All patients having outpatient surgical procedures or outpatient visits with a health care provider will be assessed for pain.

2-2. Staff education

a. The effective management of pain rests heavily upon the staff's knowledge and attitude regarding pain and pain management. All health care staff (providers, nursing, and auxiliary staff) will complete a basic educational program on pain management. This training will focus on the following areas:

(1) Pain assessment.

(2) Behaviors potentially indicating pain.

(3) Personal, cultural, spiritual, and or ethnic beliefs that may impact on a patient's perception of pain.

(4) Barriers to reporting pain and using analgesics.

(5) Pain management standards.

(6) Pain management within this MEDDAC.

b. Pain management training will be documented in staff members' Competency-based Orientation folders.

c. Annually, each clinic will conduct an inservice focusing on effective pain management to enhance staff competency in pain assessment and management. Pain management education will be a component of each provider's continuing medical education program, and continuing education programs of nursing personnel.

Chapter 3
Pain Management of Ambulatory Surgery Patients, Primary and Specialty Care Patients, and Retrospective Review

3-1. Pain management of ambulatory surgery patients

a. Pain management will be discussed during the pre-operative visit. Minimally, the following topics will be covered:

(1) The patient's usual response to pain. (How will we know you are in pain?)

(2) Post-operative pain measurement. (Demonstrate the use of the pain scale.)

(3) Post-operative pain management on the unit.

(4) Post-operative pain management at home following discharge.

b. The patient will be monitored continually throughout the post-procedure period. The nursing staff will assess post-procedure patients for pain, intervene appropriately and document the patient's response to treatment. Ongoing patient assessment for pain will also trigger key decisions to include discharge from the Post-anesthesia Care Unit to home or transfer to an alternative level of care.

c. The patient will be given the providers' clinic phone number to contact during duty hours for any difficulties following the procedure, to include unrelieved pain. The patient will also be given the on-call phone number, specific for the procedure undergone, to contact after duty hours for any difficulties following discharge, to include unrelieved pain.

d. The patients will be called at home the day after surgery to ensure that pain and other symptoms have been well controlled. If these have not been well controlled, the nurse will reinforce the discharge instructions, as indicated, and or refer the patient to the provider, as appropriate.

e. Pain will be assessed by the provider at the post-procedure follow up clinic visit.

3-2. Pain management of primary and specialty care patients

a. Patients have the right to appropriate assessment and management of pain. Pain will be assessed and documented during the initial assessment and regularly with follow up assessments.

b. Patients, and their families when appropriate, will be educated on their roles in managing pain, as well as the potential limitations and side effects of pain treatments. All providers will consider personal, cultural, spiritual, and or ethnic beliefs, communicating to patients and families that pain management is an important part of care.

c. Pain Assessment

(1) Initially, all patients will be screened for pain. They will be asked if they currently have pain or have had pain in the last several weeks or months. This information will be documented utilizing appropriate assessment forms. The Standard Form 600 (Health Record – Chronological Record of Medical Care) utilized during the patient's screening will contain the statement, "Pain, Yes/No; Current/Past; Location: _____, Intensity: ____/10 (0-10)." If the patient's pain intensity is currently 8 or higher, the individual performing the screening will inform the provider of the chief complaint and the current pain level. This criteria does not preclude use of good clinical judgement or practice guidelines.

(2) If pain is present, the provider will perform a more comprehensive assessment, as warranted by the patient's condition. For example, a patient with an acute sore throat, earache or minor laceration would not require the comprehensive pain assessment outlined below but a patient with chronic pelvic pain would.

(a) In the case of a life-threatening episode, the patient will be stabilized prior to

completing the pain assessment.

(b) In patients with stable, chronic pain, a comprehensive pain assessment will be completed when there is an increase from baseline or when pain interferes with normal function or activity.

(3) If a more comprehensive assessment is warranted, the following questions can help guide the assessment of the patient's pain level, source of pain, and needs for pain management:

(a) Pain intensity. (Use the MEDDAC's standardized pain intensity scale. See appendix B.)

(b) Location. (Point to site of pain and mark on diagram.)

(c) Quality, patterns of radiation, if any, and character. (Whenever possible, elicit and record the patient's own words.)

(d) Onset, duration, variations and patterns.

(e) Alleviating and aggravating factors.

(f) Present pain management regimen and effectiveness.

(g) Pain management history. (Including a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, and manner of expressing pain.)

(h) Effects of pain. (Impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration, etc.)

(i) The patient's pain goal. (Including pain intensity and goals related to function, activities, and quality of life.)

(j) MEDDAC Overprint (OP) 368 or MEDDAC OP 368-2 (Pain Rating, Global Rating, Patient Specific Functional Scale, and Satisfaction Self-report). (See appendix C, which illustrates MEDDAC OP 368.) (Note: MEDDAC OP 368 will be utilized by the MEDDAC's outlying clinics and MEDDAC OP 368-2 will be utilized at Kimbrough Ambulatory Care Center. The two forms are identical except in construction; MEDDAC OP 368 is printed on plain paper and MEDDAC OP 368-2 is printed on 2-part non-carbon reproducible paper.)

(k) Physical exam and or observation of the site of pain.

(4) If a patient is unable to communicate, the health care provider's observations, as follows, will be essential in deterring a current pain level.

(a) Facial and or audile expression of distress, such as grimaces, moans, crying, and noisy breathing.

(b) Ambulation and posture, such as movement in a protected or guarded fashion, limping, frequent shifting of position, and frequent stops when ambulating.

(c) Avoidance of activities, such as frequent lying down and avoidance of specific movements.

(d) Other behaviors believed to indicate pain, distress or suffering, such as wringing hands, using a cane and wearing a cervical collar.

(5) To assist in the screening and assessment of pain, enlarged laminated pain intensity scales will be available in all examination rooms. Multilingual pain scales and pain pamphlets will be assessable in all clinics. (See appendixes D and E respectfully.)

(6) If a provider observes discordance between verbal self-report of pain and associated behaviors and ability to function, further assessment will be done to ascertain the reason for the discordance. This may include a multidisciplinary clinic or an interdisciplinary team approach.

(7) The staff will encourage the reporting of pain when a patient and or family member

demonstrates reluctance to discuss pain, denies pain when pain is likely to be present (after surgery, trauma, burns or cardiac emergencies) or does not follow through with recommended treatments.

(8) Providers in Behavioral Health Care Service and Community Health Nursing, who do not regularly take vital signs, are exempted from compliance with paragraphs (1) through (7) above. These providers will screen their patients for pain by asking if they currently have pain, the location, the intensity, and whether the patient wants to be referred to his or her primary care manager (PCM). All patients with pain will be encouraged to follow up with their PCMs for pain assessment and management.

d. Pain management.

(1) The goal of patient and family education is to involve them in their pain management. Individual pain management includes ongoing pain assessment, pharmacological and non-pharmacological interventions.

(2) Based on the reason for the visit, the patient will receive information that addresses specific pain management options. The provider or nurse will educate the patient on the plan of care. This will be documented in the patient's medical record.

(3) Patient and family education should include the following:

(a) General overview.

1 Pain relief.

2 Causes of pain.

3 Assessment of pain and use of a pain rating scale to communicate pain intensity.

4 Use of a diary to record pain occurrences, intensity, times of medication, and relief.

5 Discussions with providers concerning pain and pain management.

6 Use of a preventive approach to pain control.

(b) Pharmacological management.

1 Use of drugs with specific suggestions to optimize efficacy and safety.

2 Overcoming fears of addiction (psychological dependence and drug tolerance).

3 Control of common side effects of drugs.

(c) Non-pharmacological management.

1 Deep breathing, relaxation, imagery, distraction, calming self-statements, heat, massage and exercise.

2 Health care system issues.

3 Use of effective self-advocacy skills and behaviors to obtaining pain relief.

(d) Although the majority of ambulatory patients will be able to meet their pain management education needs during their appointments, a more comprehensive patient and family education program is available for patients with pain. It will discuss the above topics in more detail.

e. Pain will be reassessed during subsequent clinic visits to determine effectiveness of treatment.

f. Consultations and referrals will be provided as appropriate to manage patients' pain.

3-3. Retrospective review

a. Each clinical area will include the evaluation of pain in their peer review and medical record review processes.

b. During review processes, determine whether pain assessment is being documented at each visit and if patients' inquiries regarding pain management are being documented.

c. Each clinical area will report the results of its pain assessments to the Medical Records Review Committee in accordance with the current reporting mechanism.

Appendix A
References

Section I
Required Publications

This section contains no entries.

Section II
Related Publications

A related publication is merely a source of additional information. It is not required to read it in order to understand this publication.

Accreditation Manual for Ambulatory Care, 2001. (Joint Commission on Accreditation of Healthcare Organizations (JCAHO)).

Acute Paint Management Guidelines Panel. Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guide-lines. Publication No. 92-0032. Rockville, MD: AHCPR, Public Health Service, U.S. Department of Health and Human Services. Feb. 1992.

AR 40-66
Medical Record Administration and Health Care Documentation

Pain Assessment and Management: An Organizational Approach. JCAHO, 2000.

VHA/DoD Clinical Practice Guideline for Management of Postoperative Pain. This guideline can be accessed at either of the following web addresses: (http://www.oqp.med.va.gov/cpg/PAIN/PAIN_GOL.htm) or (http://www.cs.amedd.army.mil/qmo/home.htm)

Section III
Prescribed Forms

MEDDAC OP 368
Pain Rating, Global Rating, Patient Specific Functional Scale, and Satisfaction Self-report. (Prescribed in para 3-2.) (For use by outlying clinics only.)

MEDDAC OP 368-2
Pain Rating, Global Rating, Patient Specific Functional Scale, and Satisfaction Self-report. (Prescribed in para 3-2.) (For use by the MEDDAC headquarters only.)

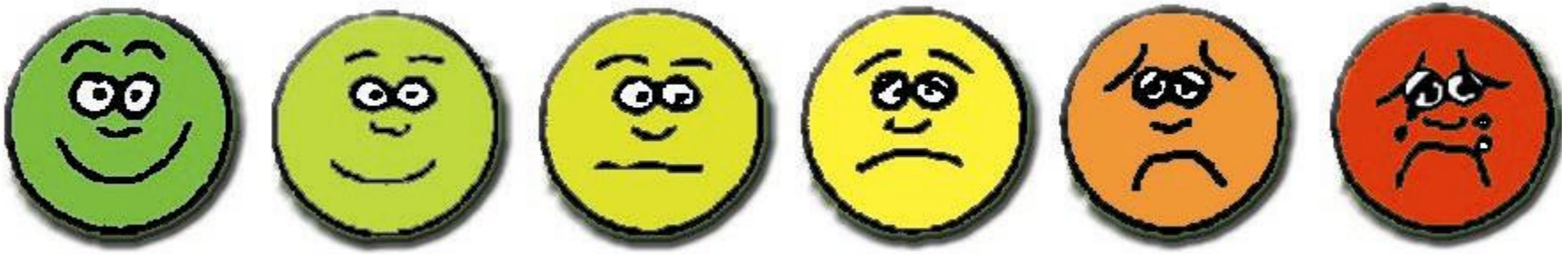
Section IV
Referenced Forms

SF 600
Health Record – Chronological Record of Medical Care

Appendix B
Whaley/Wong Pain Faces and 0-10 Pain Scale (Color)

See next page.

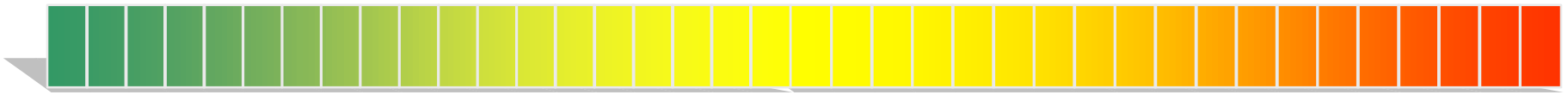
How Much Does It Hurt?



No Pain

Hurts as much as you can imagine

Pain Intensity



10 1 2 3 4 5 6 7 8 9 10

No Pain

Worst Imaginable Pain

Pain

PAIN FACES

• Explain to child that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain.

Face 0: Very happy because he doesn't hurt at all
Face 1: Hurts just a little bit
Face 2: Hurts a little more
Face 3: Hurts even more
Face 4: Hurts a whole lot
Face 5: Hurts as much as you can imagine, although you don't have to be crying to feel this bad

•Ask the child to choose the face that best describes how he/she is feeling
•Can be utilized in both children, non-English speakers, or those that speak English as a second language.
•Wong DL & Baker CM found that children ages 3-18 preferred the faces scale over the other scales but that no one scale demonstrated superiority in validity or reliability.

Whaley L, Wong DL. Nursing care of infants and children, 3rd edition, 1987. St. Louis: Mosby Co.
Wong DL, Baker CM. Pain in children: Comparison of assessment scales. Pediatric Nursing, 1988: 14(1): 9-17.

PAIN SCALE

- Please score your pain on a scale from 0-10. 0: No Pain, 10: Worse imaginable pain
- Can ask how bad has your pain been over the last 24 hours?
- Can ask what is your pain at your best? At your worst?
- Can ask what is your pain at rest? With activity?
- For rheumatological patients you can utilize the pain scale with a 24 hour slant – am pain, evening pain
- For orthopaedic post-operative patients you can ask pain at rest? Pain with range of motion?

BOTTOM LINE – JUST BE CONSISTANT WHEN YOU ASK!

Appendix C
MEDDAC Overprint 368 (Pain Rating, Global Rating, Patient Specific Function Scale, and Satisfaction Self-report)

See next page.

(See DD Form 2005 for Privacy Act Statement)

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*
PAIN RATING, GLOBAL RATING, PATIENT SPECIFIC FUNCTIONAL SCALE, AND SATISFACTION SELF-REPORT	

This form is to be completed by the patient: ☐ AD ☐ Non-Active Duty Age: _____

Occupation: _____ Number of days of pain: _____ (this episode)

Pain Limitation: Over the past **24 hours**, how much has pain limited you from performing any of your normal daily activities?

0 1 2 3 4 5 6 7 8 9 10
Activities have not been limited — Activities have been severely limited

Pain Intensity: Over the past **24 hours**, how bad has your pain been?

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as it can be

Global Rating: On a scale of 0 to 100, please rate your function of your injured body part:

Global rating: _____ 0 = no function, 100 = full function.

Functional Activity Rating: Please identify 3 important activities that you are unable to do or are having difficulty with as a result of your injury/pain:

Activity 1: _____ Please rate activity 1:

0 1 2 3 4 5 6 7 8 9 10
Unable to Perform activity — Able to perform activity at same level as prior to injury

Activity 2: _____ Please rate activity 2:

0 1 2 3 4 5 6 7 8 9 10
Unable to Perform activity — Able to perform activity at same level as prior to injury

Activity 3: _____ Please rate activity 3:

0 1 2 3 4 5 6 7 8 9 10
Unable to Perform activity — Able to perform activity at same level as prior to injury

Satisfaction: How satisfied are you with your current level of function?

0 1 2 3 4 5 6 7 8 9 10
Not Satisfied — Very Satisfied

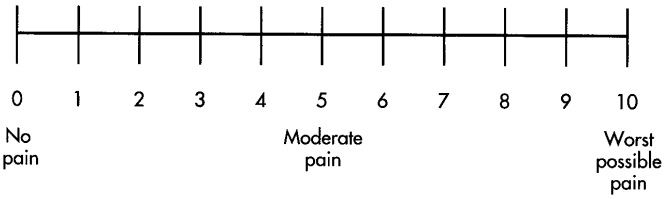
(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

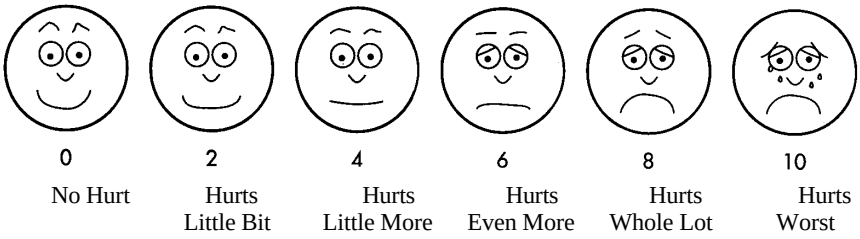
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☒ OTHER *(Specify)* Patient self-assessment
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

Appendix D
Pain Scale – Multilingual



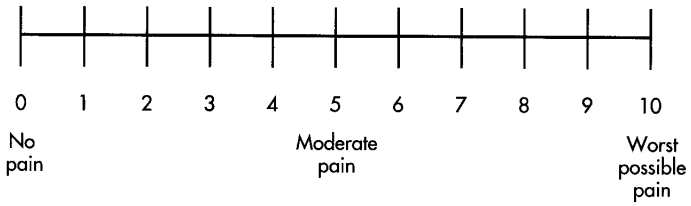
Numeric Pain Rating Scale: Ask, "If 0 is no pain and 10 is the worst possible pain, please give me a number that indicates the amount of pain you are having now."



Faces Pain Scale: Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. **Face 0** is very happy because he doesn't hurt at all. **Face 2** hurts just a little bit. **Face 4** hurts a little more. **Face 6** hurts even more. **Face 8** hurts a whole lot. **Face 10** hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the person to choose the face that best describes how he is feeling. The Wong-Baker Faces Pain Scale is recommended for persons age 3 years and older.

Faces pain rating scale modified from Wong DL: Whaley & Wong's essentials of pediatric nursing, ed 5, pp. 1215-1216, St. Louis, 1997, Mosby.

Please point to a number that best describes your pain (English)
Paki tudo ti numero nga mangipakita ti kinasakitna (**Ilocano** – spoken in the Philippines)
Por favor senale al numero que mejor describe su dolor. Mas grande el numero mayor su dolor. (**Spanish**)
Ituro po ninyo ang numerong nagpapaliwanag Kung gaano kasakit (**Tagalog** – spoken in the Philippines)
Xin chi so mo ta dung nhat su dau nhuc cua quy vj (**Vietnamese**)
현재 통증의 강도를 가장 잘 나타내는 번호에 표시하십시오. (**Korean**)



No Pain	(English)	**Terrible pain**
Awan sakit na	(Ilocano)	Nakasaksakit unay
No tiene dolor	(Spanish)	Tiene un terrible dolor
Walang masakit	(Tagalog)	Napakasakit
Khong dau	(Vietnamese)	Da rat nhieu
통증이 없음	(Korean)	통증이 너무 심함 함

Appendix E
Patient Education Brochure

See second page following.

OVERVIEW

Pain is the most common reason why individuals seek medical attention.

Unrelieved pain can have significant negative physiological and psychological effects. These include some or all of the following:

- Decreased mobility
- Impaired sleep
- Poor eating/nutrition
- Decreased concentration
- Anxiety/Distress
- Depression
- Strained social interactions

Pain may also lead to further medical complications related to:

- Nausea & Vomiting
- Elevated blood pressure
- Impaired lung function
- Impaired gastrointestinal function
- Increased metabolic rate
- Impaired immune response
- Delayed healing

WHAT IS PAIN MANAGEMENT?

The term *pain management* refers to a comprehensive approach to not only the evaluation of the source of an individual's pain but also the establishment of an appropriate treatment plan for the alleviation of both pain and suffering.

A good pain management program requires teamwork. Doctors, nurses, pharmacists, social workers, physical herapists, psychiatrists, chaplains, patients and family members all play a part.

PATIENT'S RIGHTS AND RESPONSIBILITIES

As a patient at MEDDAC, you can expect:

- Information about pain and pain relief
- A concerned staff committed to pain prevention and management
- Health professionals who respond quickly to reports of pain
- Health professionals who believe your reports of pain
- State-of-the-art pain management

As a patient at MEDDAC, we expect that you will:

- Ask your healthcare provider what to expect regarding pain and pain management
- Discuss pain relief options with your healthcare provider
- Work with your healthcare providers to develop a pain management plan
- Ask for pain relief when pain first begins
- Help your provider assess your pain
- Tell your provider if your pain is not relieved
- Tell your provider about any worries you have about taking pain medication

FT. GEORGE G. MEADE MEDDAC

Patient Information Brochure

Ft. George G. Meade MEDDAC is committed to assessing your pain and treating it appropriately. Just because you have a medical problem does not mean you have to suffer. Many options exist to help manage your pain, but to do so effectively you and your family need to be part of the treatment team.

This brochure has been written to provide you with the information you need to be an active participant in your medical care.

PAIN ASSESSMENT & MEASUREMENT

Pain Intensity

Just as it is important to have your pulse and blood pressure measured, it is equally important to have your level of pain assessed.

Everyone experiences pain differently but only you can describe the amount of pain you have.

In order to help your medical team treat your condition best, you will be asked to quantify your pain by using this simple 1-10 scale:

If this scale is at all confusing to you or any member of your family, please ask someone from your medical team to help explain it to you.

Individuals who are unable to use this scale, such as children or those with cognitive deficits, will still be assessed for pain and treated appropriately. In these situations, family members as well as medical experts may be called to help.

Pain Location & Description

In order to best treat your pain, your medical team may ask you additional information concerning your pain?

- Where is your pain located?
- Does your pain radiate to another area of your body?
- How would you describe your pain (sharp, dull, throbbing, aching, burning, etc.)?
- Is your pain constant or does it come and go?
- What makes your pain better?
- What makes your pain worse?
- Do you have trouble sleeping?
- Does your pain limit your ability perform activities such as standing, walking, bathing, dressing, taking deep breaths, etc.?
- Does your pain limit your ability to participate in the therapy you are receiving?

SETTING COMFORT GOALS

It is important that you and your medical team help establish a "comfort goal". This is a pain intensity level from 1-10, which will allow you maximum pain relief, while preserving your function.

Certainly a goal of MEDDAC is to have everyone with zero pain. Unfortunately, this may not be possible. Therefore a goal must be established.

Example*: SGT Smith recently had his knee operated on. He can expect some discomfort, but when his pain is 5 or greater he is unable to participate in his therapy. Therefore a reasonable comfort goal would be 3 or 4.*

TREATMENT OPTIONS

Today, numerous modern medications, procedures and treatment modalities are available to maximize your pain relief. They may be used independently or in combination with one another.

Medications

Some common medications include:

- Tylenol (Acetaminophen)
- Non-Steroidal Anti-inflammatory medications (NSAID's)
- Corticosteroids
- Muscle Relaxants
- Antidepressant medications
- Opiods/Narcotics
- Anticonvulsant/Seizure medications

Opioids or *Narcotics* are some of the most common and effective medications used for severe pain. Patients are often hesitant about using these medications for fear of addiction. This, however, is extremely rare when these medications are used appropriately. If you have any concerns about this, you should discuss them with your doctor.

Potential side effects include:

- Nausea
- Constipation
- Sedation
- Urinary retention
- Dry mouth
- Blood thinning

Nonpharmacological

Ice and *heat* may both be effective in relieving pain. These modalities, however, should be used with caution in individuals with poor sensation or circulation

Deep breathing exercises, visual imagery and self-relaxation techniques are also very effective. Ask if you would like learn more.

Appendix F
Equianalgesic Drug Dosing Chart

Equianalgesic* Chart: Approximate Parenteral and Oral Doses (mg)

* Equianalgesic doses are approximate; use only as a guideline. All doses must be titrated to individual's reponse. Rescue dose for breakthrough pain: Oral opioids = 10-15 % of the 24 hr dose PRN q 1-2 hrs. IV = 25% - 50% of hourly opioid infusion PRN q 15-30min generally not to exceed hourly infusion dose. If exceeds, consider increasing infusion dose. Parenteral doses are initial IM doses for severe pain in adults given q4hr; for moderate pain use 50 %; for mild pain use non-opioid or 25 %. For hourly IV infusion rate divide by 4. For patients over 70, consider lowering starting parenteral doses by 25-50 %. The oral doses are not necessarily starting doses. NR = not recommended at that dose.

Opioids/Narcotics	Parenteral IM/SQ/IV	Oral	Comments
Opioid Agonists: Morphine-like, mu agonists			
Morphine (MS Contin, Oramorph SR)	10	60 (acute) 30 (chronic)	Available as twice-daily (every 8-12 hrs) MS Contin 15, 30, 60, and100 mg sustained-release tablets. Single oral dose may require conversion of 6:1. PO: Sustained-Release: Onset = 30-60m; Peak = 90-180m; Duration = 8-12 h. IV: O = 5-10 min; P = 15-30 min; D = 3-4h. SC/IM: O = 10-20 min; P = 30-60 min; D = 3-4 h.
Codeine (Codeine, Acetaminophen w/ Codeine 30 mg)	N/A	200	Doses over 65mg may produce diminishing incremental analgesia. Oral tablets usually compounded with non-opioid. Tylenol #3 (eq) = 30mg codeine + 300mg acetaminophen*. Acetaminophen w/ codeine elixir contains 120mg acetaminophen and 12.5mg codeine/5cc. Some clinicians recommend not exceeding 1.5mg/kg of codeine because of an increased incidence of side effects w/ higher doses. PO: O = 30-60 min; P = 30-60 min;D = 4-6 h; T½ = 3-4h.
Meperidine (Demerol)	75	300	Normeperidine (toxic metabolite) accumulates with repetitive doses, causing CNS excitation. Avoid high frequent doses, chronic use, and use in patients with impaired renal function. Should not be used for more than 48hrs for acute pain or >600mg/24hrs IV. 50mg po ≈ 650mg ASA. PO: O = 30-60 min; P = 60-90 min; D = 2-4 h (all routes); T½ = 2-3 h. IV: O = 5-10 min; P = 10-15 min; SC/IM: O = 10-20 min; P = 15-30 min.
Oxycodone (Percocet, Roxicet)	---	20	Often compounded w/ non-opioid. Percocet/Roxicet = 5mg oxycodone + 325mg acetaminophen. PO: O = 30-60 min; P = 60-90 min; D = 3-4 h; T½ = 2-3 h.
Propoxyphene (Darvocet N-100)	---	130-200	65-130mg PO approximately equal 1/6 the doses listed in this chart. Propoxyphene and toxic metabolite norpropoxyphene accumulate with repetitive dosing. Darvocet-N100 (eq) = 100mg propoxyphene + 650 mg acetaminophen. PO: O = 30-60 min ; P = 60-90 min; D = 4-6 h; T½ = 6-12 h.
Fentanyl	100 mcg	---	Transdermal (Duragesic)** patches are available in 25, 50, 75, 100 mcg/hour. Useful for stable pain that is already under control in a patient who does not spike fevers and cannot take opiods by a less invasive route. Equianalgesic conversion in controversial. Divide the total 24 hour oral morphine dose (mg) by 2 to get the fentanyl dose in mcg/hr. Doses above 25 mcg should not be used in opiod-naïve patients. Reaches therpeutice serum level 12-24 hrs after initial application; may increase initial dosage after 3 days then every 6 days. Change patch every 48-72 hrs. Serum concentration decreases 50% approx. 17hrs after discontinued. IV: O = 1-5 min; P = 3-5 min; D = 0.5-4 hr; IM: O = 7-15 min; P = 10-20 min; D = 0.5-4 h; TD: O =12-16 h; P = 24 h; D =48-72 h; T½ = 13-24 h.
Remifentanil (Ultiva)	---	---	IV: O = 1-3 min; P = 2-2.5 h ; D = 4-6 h; T½ = 9-18 min. (SDS Only)
Sufentanil (Sufenta)	20 mcg	---	IV: O = 1-3 min; T½ = 2.5-3 h (SDS Only)
Other:			
Ultram (Tramadol)	---	?333 NR	Weak mu agonist which also inhibits the reuptake of norepinephrine & serotonin. Limited usefulness in cancer pain. One 50mg tablet reported to be equal to Tylenol #3 (eq). Dose w/ 1-2 tablets q 4-6hr to max. dose of 400mg/day (If >65 yrs old, limit to 300mg/day).

*Maximum recommended dose of acetaminophen 4gm/day. Risk of renal tubular necrosis, myocardial damage. Chronic ingestion of 5-8gm/day for several weeks or 3-4gm/day for 1 year has resulted in liver damage.
**Non-formulary at Kimbrough Ambulatory Care Center

Adopted from: McCaffery, M. (1995. Pain: assessment and intervention in clinical practice, Course syllabus. Los Angeles, CA (310) 649-2219 & McCaffery & Pasero. (1999). Pain: Clinical Manual, Mosby. References: American Pain Society, (1992). Principles of analgesic use in the treatment of acute pain and cancer pain, 3 rd ed. Glenview, IL: American Pain Society; Management of Cancer Pain (1994) AHCPR Pub. No 94-0592. Rockville, MD: AHCPR, U.S. Dept. of Health and Human Service

Appendix G
Training Charts

See second page following.

Pain Assessment

Quality, patterns of radiation (Description)
Aching, Burning, Cramping, Crushing, Deep Ache, Dull, Numbness, Pressure, Pulling, Radiating, Searing, Sharp, Shock-like, Shooting, Sore, Spasm, Splitting, Stabbing, Stinging, Tearing, Throbbing, , Tightening, Tingling

Location. Where does it hurt?

Timing
Onset. When did it start?
Duration. How long have you had this pain?
Patterns & Variations. Is it Intermittent or Continuous?

Intensity/Severity (0-10). How bad is the pain?
Present (now) ____
Worst ____
Acceptable level ____ (patient's intensity goal)

Alleviating Factors. What makes it better?

Aggravating. What makes it worse?

Present pain management regimen & effectiveness

Past pain management history (including a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, manner of expressing pain);

Effect if pain. Does it affect your usual daily routine? Sleep? Appetite? Relationships with other? Emotions? Concentration?

The patient's pain goal (including pain intensity (0-10)**and** goals related to function sleep, appetite, relationships with others, emotions, concentration, etc.)

Physical Exam/Examination of Pain Site

Treatment. When pain is identified, the patient received appropriate treatment or was referred for treatment within or outside the organization.

Response to treatment is documented. When pain treatment ineffective, adjustments are made.

Discharge planning identified patient's continuing physical needs to include pain management.

Behavior Scale –FLACC

Face
0 – No particular expression or smile
1 – Occasional grimace or frown, withdrawn, disinterested.
2 – Frequent to constant quivering chin, clenched jaw.
Legs
0 – Normal position or relaxed
1 – Uneasy, restless, tense
2 – Kicking, or legs drawn up
Activity
0 – Lying quietly, normal position, moves easily
1 – Squirming, shifting back and forth, tense
2 – Arched, rigid or jerking
Cry
0 – No cry (awake or asleep)
1 – Moans or whimpers; occasional complaint
2 – Crying steadily, screams or sobs, frequent complaints
Consolability
0 – Content, relaxed
1 – Reassured by occasional touching, hugging or being talked to, distractible
2 – Difficult to console or comfort

Merkel & Voepel-Lewis (1997). The FLACC: A Behavioral Scale for Scoring Postoperative Pain in Young Children. Pediatric Nursing , 23(3).

Sedation Scale:

S= Sleep, easy to arouse
1= Awake and alert
2= Slightly drowsy, easily aroused
3= Frequently drowsy, arousable, drifts off to sleep during conversation
4= Somnolent, minimal or no response to physical stimulation.

DA4700: Pain Rating, Global Rating, Patient Specific Functional Scale, and Satisfaction Self-Report

Pain Limitation:
Range: 0-10, 0= No Disability
Important to determine how pain is limiting Function

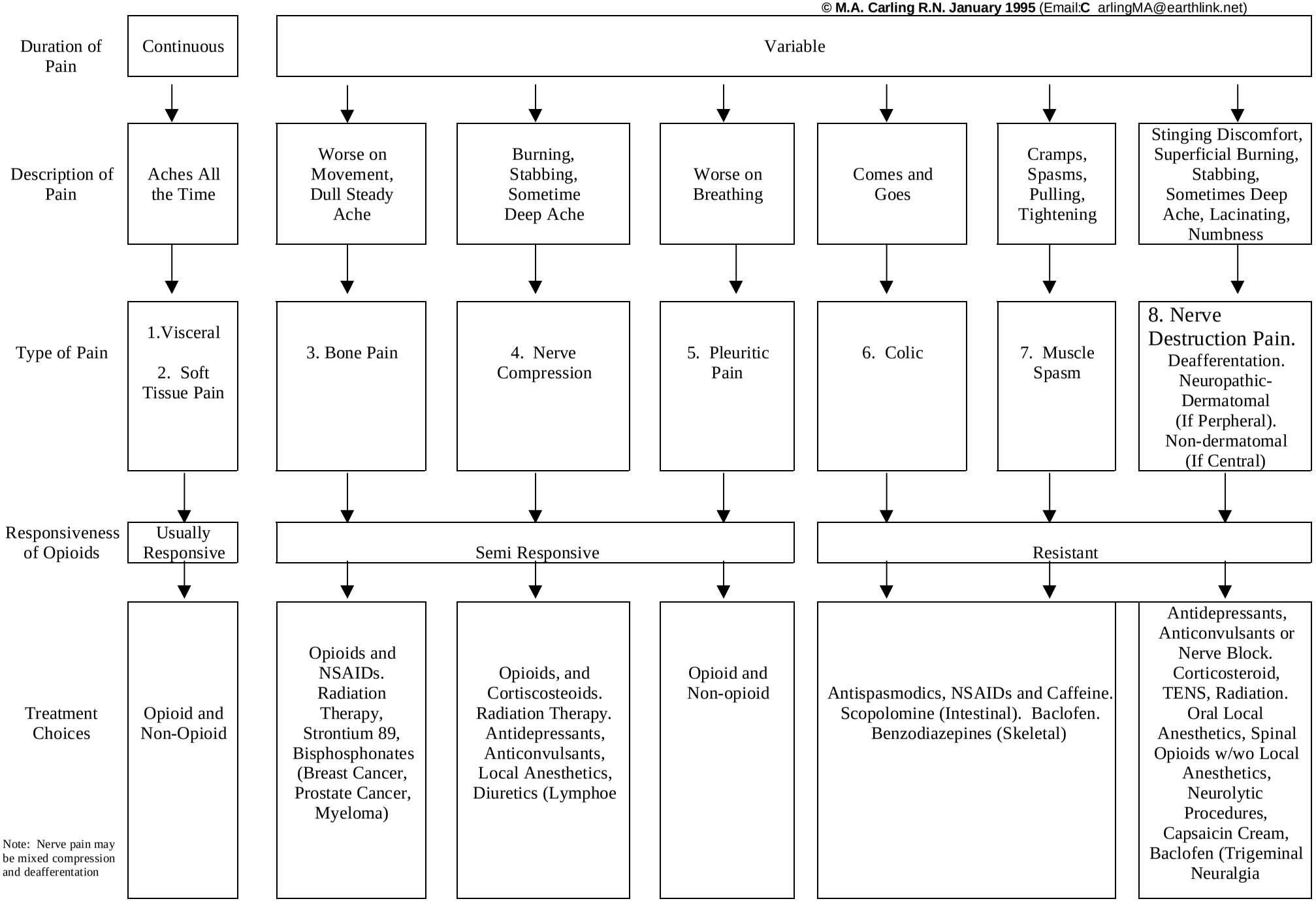
Pain Intensity:
Range 0-10, 0=No Disability
Standard Pain Scale

Global Rating:
Range 0-100, 100=No Disability
Very useful to tracking improvement
Has been proven to be reliable

Functional Activity Rating:
Patient lists three important activities
Range 0-10, 10= No Disability
A change in the score by 2.4 points is the mean detectable change to be within a 95% confidence interval.

Satisfaction:
Important to ask with chronic pain patients – because there pain level may be high – but that is their status quo or may have improved from a prior state.
Range 0-10, 10=Very Satisfied

How Does the Patient Describe the Pain?



Note: Nerve pain may be mixed compression and deafferentation

Appendix H
Knowledge and Attitude Survey Regarding Pain

See next page.

Knowledge and Attitude Survey Regarding Pain

INSTRUCTIONS:
Please answer each of the following questions by clicking the appropriate block. You may print out the survey which you may keep as a reference.

DEMOGRAPHIC INFORMATION:

POSITION:
☐ Staff Physician
☐ Physician Assistant
☐ Other Providers/Specialists
☐ Advance Practice Nurse (NP/CNS)
☐ Registered Nurse (BSN)
☐ Registered Nurse (AND)
☐ Registered Nurse (Diploma)
☐ LPN/LVN/91C
☐ 91B
☐ 91B with skill identifier
☐ Other enlisted specialty
☐ CNA
☐ Student/Intern

AGE:
☐ 15-19
☐ 20-29
☐ 30-39
☐ 40-49
☐ 50-59

YEARS OF EXPERIENCE IN YOUR CURRENT PROFESSION/JOB:
☐ 0-4 Years
☐ Greater than 4 Years

NUMBER OF HOURS OF PAIN EDUCATION:
☐ None
☐ Less than 4 hours
☐ 4-8 hours
☐ >8 hours

Do you personally have a history of a painful experience? (i.e. illness, operation, injury, childbirth, etc)
☐ Yes
☐ No

How/Where did you learn what you know about pain management?
Insert answer here:

Knowledge and Attitude Survey Regarding Pain

(Adapted from Ferrel & McCaffery , Wisconsin Cancer Pain Initiative Surveys and the MEDDAC Pain SOP)

Please check true, false, or I don't know.

True	False	I Don't Know	Question
☐	☐	☐	1. Observable changes in vital signs must be relied upon to verify a patient's statement that he has severe pain.
☐	☐	☐	2. Because of an underdeveloped nervous system, children under the age of 2, have little sensitivity to painful stimuli and limited memory of painful experiences.
☐	☐	☐	3. If the patient can be distracted from his pain this usually means that he does not have high pain intensity.
☐	☐	☐	4. Patients may sleep in spite of severe pain.
☐	☐	☐	5. Comparable noxious stimuli produce the same intensity of pain in different people.
☐	☐	☐	6. Beyond a certain does of non-opioid analgesics (e.g. Motrin, Tylenol) increases in dose will not increase pain relief.
☐	☐	☐	7. Non-drug interventions (such as distraction, imagery) used alone is usually enough to relieve pain.
☐	☐	☐	8. All patients have the right to appropriate assessment and management of pain.
☐	☐	☐	9. Pain is now considered the fifth vital sign and should be screened on all new patients.
☐	☐	☐	10. Patients with a history of substance abuse who require IV opiods should not be given patient controlled analgesia.
☐	☐	☐	11. Elderly patients cannot tolerate strong medications such as opioids for pain.
☐	☐	☐	12. Children can reliably report the intensity of their pain.
☐	☐	☐	13. The parents'assessment of the child's pain intensity is not reliable.
☐	☐	☐	14. We are required to have annual training on effective pain assessment and management.
☐	☐	☐	15. A placebo can be used to determine if pain is real.
☐	☐	☐	16. In order to be effective, heat and cold should only be applied to the painful area.
☐	☐	☐	17. Patients personal, cultural, spiritual, and/or ethnic beliefs may affect how a patient communicates his/her pain. Therefore non-verbal clues (e.g. not able to sit still, constantly changing positions, visible distress on one's face) are important in determining a pain management plan.
☐	☐	☐	18. If I am screening an individual with pain and their pain level is≥ 8/10, my responsibility is to inform that patient provider of the patient's chief complaint and his/her current pain intensity.
☐	☐	☐	19. During medical record review we must include pain assessment/management in the process.
☐	☐	☐	20. Pain faces can be used with children. Although the standard pain intensity scale is just as reliable and valid, children 3-18 preferred the use of pain faces.

Please pick the most appropriate answer:

21. The most likely reason why a patient with pain would request an increased dose of pain medication is:
    - ☐ A. The patient is experiencing increased pain
    - ☐ B. The patient is experiencing increased anxiety or depression
    - ☐ C. The patient has become physically dependent to the medication
    - ☐ D. The patient is becoming addicted
    - ☐ E. I don't know

22. The most accurate judge of the intensity of the patient's pain is:
    - ☐ A. The treating physician
    - ☐ B. The patient's primary nurse
    - ☐ C. The pharmacist
    - ☐ D. The patient
    - ☐ E. The patient's spouse or family
    - ☐ F. I don't know

23. Opioid (narcotic) addiction is defined as psychological dependence accompanied by overwhelming concern with obtaining and using opioids for psychic effect, not for medical reasons. It may occur with or without the physiological changes of tolerance to analgesia and physical dependence (withdrawal). Using this definition, how likely is it that opioid addiction will occur as a result of treating pain with opioid analgesics.
    - ☐ A. <1%
    - ☐ B. 1-5%
    - ☐ C. 5-10%
    - ☐ D. 10-25%
    - ☐ E. 25-50%
    - ☐ F. 50-75%
    - ☐ G. 75-100%
    - ☐ H. I don't know

24. What do you think is the percentage of patients who over report the amount of pain they have?
    - ☐ A. 0-10%
    - ☐ B. 10-20%
    - ☐ C. 20-30%
    - ☐ D. 30-40%
    - ☐ E. 40-50%
    - ☐ F. 50-60%
    - ☐ G. 60-70%
    - ☐ H. 70-80%
    - ☐ I. 80-90%
    - ☐ J. 90-100%
    - ☐ H. I don't know

25. The pain intensity charts are located in _____ to help assist with screening of pain intensity. Multilingual pain charts are located at the _____ if the patient does not speak/read English.

QUESTIONS TO BE ANSWERED BY PRIMARY CARE PROVIDERS (PCMs) AND OTHER STAFF AS DETERMINED BY THEIR SUPERVISOR:

Please pick true, false, or I don't know.

True	False	I Don't Know	Question
☐	☐	☐	26. Respiratory depression rarely occurs in patients who have been receiving opioids over several months
☐	☐	☐	27. The usual duration of action of meperidine (Demerol) is 4 hours.
☐	☐	☐	28. Research shows that promethazine (Phenergan) is a reliable potentiator of opioid analgesia.
☐	☐	☐	29. Beyond a certain dose of opioid (Morphine, Dilaudid), increases in dose will not increase pain relief.
☐	☐	☐	30. Opioid analgesics are best ordered on a "prn" basis to encourage minimal dosing and reduce the risk of addiction.
☐	☐	☐	31. Following an initial dose of anopioid analgesic, subsequent doses should be adjusted in accordance with the individual patient's response.
☐	☐	☐	32. Anticonvulsant drugs such as carbamazepine (Tegretol) produce optimal pain relief after a single dose.
☐	☐	☐	33. Although benzodiazepines provide relief of painful muscle spasm, they are not effective analgesics.
☐	☐	☐	34. Local anesthetics may provide relief ofneuropathic pain that is unresponsive to other drugs.
☐	☐	☐	35. Lancinating pain may be particularly responsive to therapy with anticonvulsant drugs.
☐	☐	☐	36. Treatment of neuropathic pain with amitriptyline is often compromised by sedation, urinary retention, andorthostatic hypotension.
☐	☐	☐	37. Haloperidol has prominent analgesic properties
☐	☐	☐	38. Adjuvant analgesics such as thetricyclic antidepressants and anticonvulsants should not be used in combination withopioid analgesics or NSAIDS.
☐	☐	☐	39. If opioids (narcotics) are used during the pain evaluation periods, they will mask your ability to correctly diagnose the cause of pain.

Please pick the most appropriate answer:

40. The recommended route of administration ofopioid analgesics to patients with brief, severe pain of sudden pain of sudden onset, e.g. trauma or postoperative pain , is

☐A. Intravenous
☐B. Intramuscular
☐C. Subcutaneous
☐D. Oral
☐E. Rectal
☐F. I don't know

41. Analgesics for post-operative pain should initially be given
    - ☐ A. Around the clock on a fixed schedule
    - ☐ B. Only when the patient asks for the medication
    - ☐ C. Only when the nurse determines that the patent has moderate or greater discomfort
    - ☐ D. I don't know

42. Chronic use of which of the following medications may cause tremors, myoclonus, or seizures because of the accumulation of a long-lived metabolite which is a CNS stimulant?
    - ☐ A. Methadone
    - ☐ B. Oxycodone (Percocet, Tylox)
    - ☐ C. Trandermal Fentanyl (Duragesic)
    - ☐ D. Meperidine (Demerol)
    - ☐ E. I don't know

43. The degree of all but one of the following side effects will decrease after repeated administration of an opioid analgesic. Which side effect will not decrease?
    - ☐ A. Sedation
    - ☐ B. Nausea
    - ☐ C. Constipation
    - ☐ D. Respiratory Depression
    - ☐ E. I don't know

Answer Key:

1. False
2. False
3. False
4. True
5. False
6. True
7. False
8. True
9. True
10. False
11. False
12. True
13. False
14. True
15. False
16. False
17. True
18. True
19. True
20. True
21. A
22. D
23. A
24. A
25. Exam & Screening Rooms/Clinic Specific
26. True
27. False
28. False
29. False
30. False
31. True
32. False
33. True
34. True
35. True
36. True
37. False
38. False
39. False
40. A
41. A
42. D
43. C

Glossary

Section I
Abbreviations

DCCS
Deputy Commander for Clinical Services

DCN
Deputy Commander for Nursing

JCAHO
Joint Commission on Accreditation of Healthcare Organizations

MEDDAC
U.S. Army Medical Department Activity, Fort George G. Meade

OP
overprint

PCM
primary care manager

Section II
Terms

This section contains no entries.